

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 004440	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/02/2011
NAME OF PROVIDER OR SUPPLIER CHANDLER HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 2879 S LIMA ROAD KENDALLVILLE, IN 46755		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on June 1, 2011.</p> <p>Survey date: August 2, 2011</p> <p>Facility number: 004440 Provider number: 004440 AIM number: N/A</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: Residential: 24</p> <p>Census payor type: Other: 24</p> <p>Sample: 3</p> <p>Chandler House was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure Survey.</p> <p>Quality review completed on August 2, 2011 by Bev Faulkner, RN</p>	{R 000}		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

EMG412

If continuation sheet 1 of 1